SESSION 1130 (PAPER)

DISPARITIES IN HEALTH STATUS AND HEALTH CARE

RACIAL AND ETHNIC DISPARITIES IN 30-DAY READMISSION RATES IN MEDICARE ADVANTAGE AND MEDICARE FEE-FOR-SERVICE

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It is unclear whether improvements in readmission rates have accompanied improvements for all White, African-American and Hispanic beneficiaries, and whether differences among these groups have narrowed over time. Using national Medicare Provider and Analysis Review Files linked with the Medicare Advantage Healthcare Effectiveness Data and Information Set, we examined 30-day all-cause readmission for three conditions: acute myocardial infraction (AMI), heart failure (HF), and pneumonia from 2011 and 2014 by race and ethnic group. We calculated raw differences and also used generalized linear models adjusting for demographic characteristics and up to 39 co-morbidities. In 2011, unadjusted rates were 18.9% (African-American) vs. 17.1% (Hispanic) vs.15.2% (white) for AMI; 24.6% vs. 24.5% vs.22.0% for HF; and 21.5% vs.20.0%, vs.17.9% for pneumonia. Among African-Americans, adjusted readmission rates declined by 3.2 percentage points in AMI, 4.3 percentage points in HF, and 3.4 percentage points in pneumonia. The corresponding declines among whites were 2.9, 3.2, and 2.4; and among Hispanics were 3.0, 4.1, and 3.4. The magnitude of the disparity between white patients and African-Americans narrowed significantly for HF and pneumonia (0.6 [CI: 1.2 to 0.2] and 0.8 [1.3 to 0.3]). Among Hispanics and whites, the magnitude of the disparity significantly changed for pneumonia (0.9 [CI: 1.5 to 0.3]), but was unchanged for the two other conditions. We observed similar trends in stratified analysis by Medicare Advantage vs. fee-for-service enrollment. Interventions that are focused on minority groups and minority-serving hospitals are still needed to decrease disparities in readmission rates.

USING IPD META-ANALYSIS TO EXPLORE HEALTH AND CARE INEQUALITIES AMONG LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

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Background: Modelling the health and care trajectories of lesbian, gay, bisexual and transgender (LGBT) is essential to identify health inequalities and support needs, yet because of the small sample of LGBT people in any one survey, current evidence relies on studies that have poor generalisability and low power. This lack of data results in knowledge gaps for decision-makers seeking to plan health and care services for LGBT people. Objectives: This presentation will (i) describe differential ageing trajectories followed by older LGBT people through presenting results from a scoping review; (ii) demonstrate how different approaches to identifying LGBT people in large surveys leads to a differential understanding of public health challenges; (iii) assess health inequalities using exemplar evidence on alcohol consumption and wellbeing from Individual Participant Data (IPD) Meta-analysis of UK data. Methods: IPD meta-analysis allows more flexible, complex statistical analysis of study data. Use of IPD meta-analysis to explore LGBT health and care differentials is a novel application in exploring issues of health and care equity based on sexuality in later life, and the results for measures of quality of life and alcohol consumption will be presented. Results: Early results suggest inequalities in health are particularly visible for older LGB women. Furthermore, the wellbeing of this group may be compromised further by other age-related transitions, such as the adoption of family caring duties at a much earlier age. Measurement issues around the identification of people as being LGBT within large scale surveys are also examined.

IMPACT OF RACISM ON MINORITY ELDERS NOT RECEIVING HEALTHCARE: MEDIATING ROLE OF POOR DOCTOR-PATIENT COMMUNICATION

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Little is known about factors that contribute to delayed/forgone care in racial/ethnic minority older adults. We investigated if perceived racial/ethnic discrimination is associated with delayed/forgone care, and whether poor doctor-patient communication mediates this relationship in minority older adults. Data from the 2015 California Health Interview Survey were used. We limited our sample to adults ages 65 or older with complete covariates (n=6,972 unweighted). Using a cross-sectional survey research design and a population-based sampling strategy, we conducted multivariable logistic regression analyses to estimate odds of having delayed or forgone care when adjusted for other covariates. Then, we performed mediation analyses to investigate whether poor doctor-patient communication mediates the relationship. We also performed stratified mediation analyses by race/ethnicity. In the full model, those who experienced racial/ethnic discrimination had 2.29 times higher odds of having delayed/forgone care (95% CI, 1.02–5.17) than did those who did not have such experiences. Having poor communication with a doctor had 3.07 times higher odds of having delayed/forgone care (95% CI, 1.98–4.75). In the adjusted mediation analysis, we confirmed that poor doctor-patient communication was a mediator. When stratified by race/ethnicity, neither perceived racial/ethnic discrimination nor doctor-patient communication was associated with delayed/forgone care among non-Hispanic whites. In contrast, among minority older adults, racial/ethnic discrimination was significantly associated with delayed/forgone care (odds ratio=3.60; 95% CI, 1.24–10.51), and the effect mediated by poor doctor communication was 9.9%. Findings suggest that improving doctor-patient interactions may reduce disparities in access to care in minority older adults.

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